Exhibit D
Medical File of Rodney Julius Owens

SOUTHERN RADIOLOGY SERVICES, LLC
X-RAY REPORT

DATE	LAST NAME	FIRST NAME	MI
6/13/2006	OWENS	RODNEY	
D.O.B.	**SEX**	**FACILITY**	
[redacted]		LEE COUNTY JAIL	
ORDERING PHYSICIAN		**X-RAY NO.**	
MCFARLAND		MT10113	

RIGHT ANKLE – THREE VIEWS

FINDINGS: No right marker is seen on the submitted images. There sor e moderate soft tissue swelling over the lateral malleolus. No fracture c disl oc i or identified.

DICTATED BUT NOT REVIEWED

Randall Finley, M.D./cdw

tt: 6/13/2006 5:25:15 PM
td: 6/13/2006 3:59:16 PM

MEDICATION SHEET - ADMINISTRATION RECORD

P & L FORMS #3021 *(for A03 print programs)*

June 2006

Medications | Hour | 1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24 25 26 27 28 29 30 31

Flexeril 10 mg #10 ÷ BP
06/13/06
0800
2100

Naprosyn 500 mg #14 ÷ BP
06/13/06
0800
2100
Complete

Naprosyn 375 mg BID #20
6/20/06
0800
2100

rev 2-3 wks
6/20/06

ankle Flexion splint (R) ankle
6/20/06
K
OP
KOP

	1	1	2	2	3	3	4	4	5	5	6	6	7	7	8	8	9	9	10	10	11	11
AM																						
PM																						
	12	12	13	13	14	14	15	15	16	16	17	17	18	18	19	19	20	20	21	21	22	22
AM																						
PM									AE.													
	23	23	24	24	25	25	26	26	27	27	28	28	29	29	30	30	31	31				
AM																						
PM										JS.												

Charting For _____ Through June 2006

Physician Yvette Farland MA | Telephone No. | Medical Record No.

Alt. Phys. | Alt. Telephone

Allergies | Rehabilitative Potential

Diagnosis | Admission Date

Medicaid Number | Medicare Number | Complete Entries Checked: By: Stewart Title: LPN Date: 6/13/06

Resident | Birth Date | Resident Code | Room No. | Bed | Facility Code

MEDICATION SHEET - ADMINISTRATION RECORD

P & L FORMS #3021 *(for A03 print programs)*

June 2006

Medications	Hour
Naprosyn 500mg BID #14 (5/31/06) 06/1/06	1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24 25 26 27 28 29 30 31

	1	1	2	2	3	3	4	4	5	5	6	6	7	7	8	8	9	9	10	10	11	11
AM	MC		OA																			
PM	J.S.				DW				LK		AF											
	12	12	13	13	14	14	15	15	16	16	17	17	18	18	19	19	20	20	21	21	22	22
AM																						
PM																						
	23	23	24	24	25	25	26	26	27	27	28	28	29	29	30	30	31	31				
AM																						
PM																						

Charting For Through

Physician McFarland

Alt. Phys.

Aller-gies

Diag-nosis

Telephone No.

Alt. Telephone

Rehabilitative Potential

Medical Record No.

Admission Date

Medicaid Number | Medicare Number | Complete Entries Checked: By: Title: LPN Date: 5/31/06

Resident | Birth Date | Resident Code | Room No. | Bed | Facility Code

MEDICATION ADMINISTRATION RECORD

MEDICATIONS	HOUR	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31
Wt q 1-2 wk 2/28/06 3/1/06	0800	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31
		1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31
		1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31
		1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31
Wt 170#		1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31
		1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31
		1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31
		1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31
		1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31
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		1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31
		1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31
		1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31
		1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31
		1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31
		1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31
		1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31
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		1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31
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		1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31
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		1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31
		1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31
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		1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31
		1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31
		1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31
		1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31
		1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31
		1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31
		1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31
		1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31
		1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31
		1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31
		1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31
		1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31
		1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31

REORDER FROM INTEGRAL SOLUTIONS GROUP • 1-800-235-0767 FORM A-55 STOCK #506423

ARTING FOR	THROUGH
sician McFarland	Telephone No.
Physician	Alt. Telephone
gies	Rehabilitative Potential
nosis	
Medical Record No.	
Medicaid Number	Medicare Number
Approved By Doctor: By: L Stewart	Title: Lpn Date:
ESIDENT	D.O.B.
Sex	Room # 7-1
Patient Code	Admission Date

MEDICATION ADMINISTRATION RECORD

MEDICATIONS	HOUR	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31
Tylenol ES 500mg 2 tabs po PRN pain/fever	PRN																															
Motrin 200mg 2 tabs po PRN pain	PRN																															

REORDER FROM INTEGRAL SOLUTIONS GROUP • 1-800-235-0767 FORM A-55 STOCK #506423

RTING FOR THROUGH

ician Telephone No. Medical Record No.

Physician Alt. Telephone

gies Rehabilitative Potential

nosis

edicaid Number Medicare Number Approved By Doctor: By: Title: LPN Date: 2/8/06

SIDENT D.O.B. Sex Room # F-1 Patient Code Admission Date

MEDICATION SHEET - ADMINISTRATION RECORD

P & L FORMS #3021 *(for A03 print programs)*

MAY 2006

Medications	Hour	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31
Motrin OTC 1 tab PO prn pain 05/30/06 MD	0800																															
	2100																															

	1	1	2	2	3	3	4	4	5	5	6	6	7	7	8	8	9	9	10	10	11	11
AM	DEPUTY	STEWART	DEPUTY	STEWART	DEPUTY	STEWART	DEPUTY	STEWART														
PM	DEPUTY	STEWART	DEPUTY	STEWART	DEPUTY	STEWART	DEPUTY	STEWART														
	12	12	13	13	14	14	15	15	16	16	17	17	18	18	19	19	20	20	21	21	22	22
AM																						
PM																						
	23	23	24	24	25	25	26	26	27	27	28	28	29	29	30	30	31	31				
AM																						
PM															AL	RO						

Charting For Through

Physician		Telephone No.	Medical Record No.
Alt. Phys.	P Motorcade	Alt. Telephone	
Aller-gies		Rehabilitative Potential	
Diag-nosis			Admission Date
Medicaid Number	Medicare Number	Complete Entries Checked: By: Stewart Title:	Date:
Resident		Birth Date	Resident Code / Room No. / Bed / Facility Code

Mrs Stewart Copy #3

Regardless of whether the indifference to the Serious medical needs of prisoners is manifested by prison doctors in there responce to the prisoners needs, or by prison Guards in Intentionally delaying or denying access to medical care. Or Intentionally Interfering with the treatment once prescribed, it is actionable under the Civil rights Statute. a Constitution Claim is Stated when prison officials Intentionally deny access to medical Care or Interfere with prescribed Treatment. The most Immediate Concern under the Eight amendment or it may Result in pain + Suffering which Serves no penological purpose.

Thanks

Rody Mays

Copy #2

Time 8:20 AM

ee County Detention Center

INMATE REQUEST SLIP

E-9
LOCATION

Name Rodney Owens Date 06/21/06

☐ Telephone Call ☒ Doctor ☐ Dentist ☐ Time Sheet

☐ Special Visit ☐ Personal Problem ☐ Other

Briefly Outline Your Request, Give To Jailer

I am filing a Grievance against Doctor John McFarland + Nurse Stuart for not X-Ray my Back Injury and Dr. need for Back pain

Witness Inmate Buchanan

Do Not Write Below This Line - For Reply Only

Dr. McFarland is our medical director and is a licensed doctor, his recommendations and protocol are of any physician that you would go to any where else.

1st. Cory D. Welch

Approved _____ Denied _____ Collect Call 6-22-06

All Request Will Be Routed Through The Sergeant Over The Jail, Then Forwarded To Those The Request is Directed.

☐ Lieutenant ☐ Chief Deputy ☐ Sheriff

ALABAMA / MISSISSIPPI
1-800-845-8183

Mont-4

SOUTHERN RADIOLOGY SERVICES, LLC

Please Indicate Patient Status:
- Bill Facility (Medicare Part A Skilled)
- Bill Insurance (3rd Party Non Skilled)
- Hospice
- Employee

PLEASE PRINT

PATIENT: Owens, Rodney (Last, First, MI)
DOB: [redacted] SEX: (M) F ROOM #:
FACILITY: LCDC CODE
PHONE: [redacted] FAX: [redacted]
SS# [redacted]
MEDICARE #: CODE
MEDICAID #: CODE
INSURANCE: CODE
INSURANCE #: PRE CERTIFICATION #

RESPONSIBLE PARTY INFORMATION
(MUST BE COMPLETED FOR ALL PATIENTS)

NAME: PHONE #: ( )
ADDRESS:
CITY: LEE COUNTY DETENTION CENTER STATE: ZIP:
P.O. BOX 2407
OPELIKA, AL 36803

PATIENT SIGNATURE: _____

Patient's or Authorized Person's Signature. I authorized the release of any medical or other information necessary to process this claim. I request payment of government/insurance benefits be made to the provider performing services.

☐ Patient Unable to Sign

EXAMS REQUESTED: Please Mark Each Clearly

X-RAY EXAMS

	74000	Abdomen, 1 View		73520	Hip, Min 2 Views w/Pelvis L R		73590	Tibia/Fibula, 2 Views L R
	73600	Ankle, 2 Views (AP 7 LAT) L R		73510	Hip, Comp Min 2 Views L R		73100	Wrist, 2 Views L R
✓	73610	Ankle, Comp Min 3 Views L (R)		73060	Humerus, Min 2 Views L R		73110	Wrist, Min 3 Views L R
	73650	Calcaneus (Heel), 2 Views L R		73560	Knee, 2 Views L R			OTHER _____
	71010	Chest, 1 View (AP)		73562	Knee, 3 Views (inc OBLQ) L R			OTHER EXAMS L R
				70160	Nasal Bones, Comp Min 3 Views			
	71111	Chest With Ribs, 4 Views		72170	Pelvis, 1 Views			
	73000	Clavicle, Complete L R		71100	Ribs, 2 Views L R		93000	EKG Pacemaker: Y N
	73070	ELbow, 2 Views L R		72220	Sacrum/Coccyx, Min 2 Views		95819	EEG
	73080	Elbow, Comp 3 Views L R		73030	Shoulder, Min 2 Views L R			
	73550	Femur, 2 Views L R		70210	Sinuses, Less Than 3 Views			
	73620	Foot, 2 Views L R						
	73630	Foot, Comp Min 3 Views L R		70250	Skull, Less Than 4 Views			
	73090	Forearm, 2 Views L R		72040	Spine, Cervical 2 Views			
	73120	Hand, 2 Views L R		72100	Spine, Lumbosacral 2 Views			
	73130	Hand, Min 3 Views L R		72070	Spine, Thoracic 2 Views			

DIAGNOSIS/SYMPTOM(S): Please Mark ALL that apply

	787.3	Abdomen Distention (Flatulence)		496	COPD, Chronic Obstructive Pulm. Dis.		560.9	Obstruction, Intestinal
	787.5	Abnormal Bowel Sounds		786.2	Coughing		_____	Pain in _____
	413.0	Angina		_____	Dislocation of _____		485	Pneumonia, Confirmed
	_____	Arthritis of		780.4	Dizziness		514	Pneumonia, Probable
	429.2	ASCVD, Arteriosclerotic cardiovas. Dis.		787.2	Dysphagia (Difficulty Swallowing		795.5	Positive Mantoux, PPD
	427.31	Atrial Fibrillation		782.3	Edema (Swelling)		518.4	Pulmonary Edema, NOS
	507.0	Aspiration		492.0	Emphysema		515	Pulmonary Fibrosis
	427.89	Bradycardia		780.6	Febrile (Feverish)		786.7	Rales in Chest
	_____	Bruise of _____	✓	_____	Possible Fracture of _____		786.09	Shortness of Breath
	466.0	Bronchitis, NOS		560.39	Impaction		780.2	Syncope & Collapse
	_____	Carcinoma of _____		518.3	Infiltrate, Lung		785.0	Tachycardia
	429.3	Cardiomegaly		410.92	Myocardial Infarction		011.90	Tuberculosis
	786.50	Chest Pain, Unspecified		787.01	Nausea and Vomiting		519.8	URI (Chronic)
	514	Congestion, Chest						
	428.0	Congestive Heart Failure						OTHER _____

PHYSICIAN'S SIGNATURE: _____

Because of physical psychological and/or age limitations, this patient would find it difficult to receive this/these procedure(s) at a fixed site. I certify that this/these procedure(s) is/are medically necessary for the proper treatment of this patient.

RADIOLOGIST:

NURSE'S SIGNATURE: Stewart LPN

ORDERING PHYSICIAN: Dr. Mrs. Parker CODE

PHONE #: (334) 737-3591 (First, Last)

FAX: (334) 737-3574

X-RAY # TECH: K.T

DATE: 6.13.06 #VIEWS: 3

ARRIVE TIME: Q0092 # 1

DEPART TIME: # PTS SEEN 1

PRELIMINARY REPORT:

AM

LEE COUNTY DETENTION CENTER
MEDICAL CHARGE FORM
(FORM #33)

INMATE NAME Owens Rodney

DATE OF BIRTH _____ **RACE/SEX** _____

SOCIAL SECURITY# _____ **CELL** F-1

SERVICES & FEES

☐ SICK CALL	$10.00
☐ DOCTOR VISIT	$10.00
☐ DENTIST VISIT	$10.00
☒ PRESCRIPTION	$3.00 Naprosyn
☐ FOLLOW-UP VISIT	N/A
*Ankle splint	$5.00
TOTAL OF MEDICAL SERVICES RENDERED	$ 8.00

MEDICAL VERIFICATION SECTION

Authorized Nursing Staff Signature & Date [signature] 6/20/06

Inmate Signature & Date Copay

Inmate Account Payable Clerk Signature & Date

[signature]

☐ PLEASE CHECK IF INMATE IS INDIGENT TO PAY THE ABOVE CHARGES.

☐ PLEASE CHECK IF INMATE IS ABLE TO PAY THE ABOVE CHARGES.

LEE COUNTY DETENTION CENTER
MEDICAL CHARGE FORM
(FORM #33)

INMATE NAME Owens, Rodney

DATE OF BIRTH _____ **RACE/SEX** _____

SOCIAL SECURITY# _____ **CELL** 7-1

SERVICES & FEES

☐ SICK CALL	$10.00
☐ DOCTOR VISIT	$10.00
☐ DENTIST VISIT	$10.00
☑ PRESCRIPTION	$3.00
☐ FOLLOW-UP VISIT	N/A

Flagyl 500 mg 10 5.00

TOTAL OF MEDICAL SERVICES RENDERED $ 11.00

MEDICAL VERIFICATION SECTION

Authorized Nursing Staff Signature & Date L. Stewart 6/13/06

Inmate Signature & Date G. Owens

Inmate Account Payable Clerk Signature & Date

Jak

☐ PLEASE CHECK IF INMATE IS INDIGENT TO PAY THE ABOVE CHARGES.

☐ PLEASE CHECK IF INMATE IS ABLE TO PAY THE ABOVE CHARGES.

NOTES

NAME Owens, Rodney SS# [redacted]

DOB: [redacted] AGE: 46 SEX: M RACE W

DRUG ALLERGIES: none TETNUS: _____

NATURE OF PROBLEM OR REQUEST: re-check

I CONSENT TO BE TREATED BY HEALTH STAFF FOR THE CONDITION DESCRIBED.

_____
SIGNATURE

HEALTH CARE DOCUMENTATION 1702

SUBJECTIVE:

OBJECTIVE: BP _____ P _____ R _____ T _____ O2 _____

ASSESSMENT:

Dictation pending

PLAN:

Antibiotics + 2-3 more

REFER TO _____PA/PHYSICIAN_____MENTAL HEALTH_____DENTAL_____

SIGNATURE JOHN H MCFARLAND MD TITLE MD DATE 7/6/06 TIME 1758

AM8 104894
AI 11404

To Kilby 7/10/06

ALABAMA / MISSISSIPPI
1-800-845-8183

Mont-4

SOUTHERN RADIOLOGY SERVICES, LLC

Please Indicate Patient Status:
Bill Facility (Medicare Part A Skilled)
Bill Insurance (3rd Party Non-Skilled)
Hospice
Employee

PLEASE PRINT

PATIENT: Owens, Rodney (Last, First, MI)
DOB: [redacted] SEX: (M) F ROOM #:
FACILITY: LCDC CODE
PHONE: [redacted]91 FAX: 7[redacted]
SS# [redacted]
MEDICARE #: CODE
MEDICAID #: CODE
INSURANCE: CODE
INSURANCE #: PRE CERTIFICATION #

RESPONSIBLE PARTY INFORMATION
(MUST BE COMPLETED FOR ALL PATIENTS)

NAME: PHONE #: ( )
ADDRESS:
CITY: LEE COUNTY DETENTION CENTER STATE: ZIP:
P.O. BOX 2407
OPELIKA, AL 36803

PATIENT SIGNATURE: _____

Patient's or Authorized Person's Signature. I authorized the release of any medical or other information necessary to process this claim. I request payment of government/insurance benefits be made to the provider performing services.

☐ Patient Unable to Sign

EXAMS REQUESTED: Please Mark Each Clearly
X-RAY EXAMS

	74000	Abdomen, 1 View		73520	Hip, Min 2 Views w/Pelvis L R		73590	Tibia/Fibula, 2 Views L R
	73600	Ankle, 2 Views (AP 7 LAT) L R		73510	Hip, Comp Min 2 Views L R		73100	Wrist, 2 Views L R
✓	73610	Ankle, Comp Min 3 Views L (R)		73060	Humerus, Min 2 Views L R		73110	Wrist, Min 3 Views L R
	73650	Calcaneus (Heel), 2 Views L R		73560	Knee, 2 Views L R			**OTHER** _____
	71010	Chest, 1 View (AP)		73562	Knee, 3 Views (inc OBLQ) L R			**OTHER EXAMS** L R
				70160	Nasal Bones, Comp Min 3 Views			
	71111	Chest With Ribs, 4 Views		72170	Pelvis, 1 Views			
	73000	Clavicle, Complete L R		71100	Ribs, 2 Views L R		93000	EKG Pacemaker: Y N
	73070	ELbow, 2 Views L R		72220	Sacrum/Coccyx, Min 2 Views		95819	EEG
	73080	Elbow, Comp 3 Views L R		73030	Shoulder, Min 2 Views L R			
	73550	Femur, 2 Views L R		70210	Sinuses, Less Than 3 Views			
	73620	Foot, 2 Views L R						
	73630	Foot, Comp Min 3 Views L R		70250	Skull, Less Than 4 Views			
	73090	Forearm, 2 Views L R		72040	Spine, Cervical 2 Views			
	73120	Hand, 2 Views L R		72100	Spine, Lumbosacral 2 Views			
	73130	Hand, Min 3 Views L R		72070	Spine, Thoracic 2 Views			

DIAGNOSIS/SYMPTOM(S): Please Mark ALL that apply

	787.3	Abdomen Distention (Flatulence)		496	COPD, Chronic Obstructive Pulm. Dis.		560.9	Obstruction, Intestinal
	787.5	Abnormal Bowel Sounds		786.2	Coughing		_____	Pain in _____
	413.0	Angina		_____	Dislocation of _____		485	Pneumonia, Confirmed
	_____	Arthritis of		780.4	Dizziness		514	Pneumonia, Probable
	429.2	ASCVD, Arteriosclerotic cardiovas. Dis.		787.2	Dysphagia (Difficulty Swallowing		795.5	Positive Mantoux, PPD
	427.31	Atrial Fibrillation		782.3	Edema (Swelling)		518.4	Pulmonary Edema, NOS
	507.0	Aspiration		492.0	Emphysema		515	Pulmonary Fibrosis
	427.89	Bradycardia		780.6	Febrile (Feverish)		786.7	Rales in Chest
	_____	Bruise of _____	✓	_____	Possible Fracture of _____		786.09	Shortness of Breath
	466.0	Bronchitis, NOS		560.39	Impaction		780.2	Syncope & Collapse
	_____	Carcinoma of _____		518.3	Infiltrate, Lung		785.0	Tachycardia
	429.3	Cardiomegaly		410.92	Myocardial Infarction		011.90	Tuberculosis
	786.50	Chest Pain, Unspecified		787.01	Nausea and Vomiting		519.8	URI (Chronic)
	514	Congestion, Chest						
	428.0	Congestive Heart Failure						**OTHER** _____

PHYSICIAN'S SIGNATURE: _____

Because of physical psychological and/or age limitations, this patient would find it difficult to receive this/these procedure(s) at a fixed site. I certify that this/these procedure(s) is/are medically necessary for the proper treatment of this patient.

RADIOLOGIST:

NURSE'S SIGNATURE: Stewart (gm)

ORDERING PHYSICIAN: D Mc Farlane CODE
(First Last)

PHONE #: (334) 737-3591

FAX: (334) 737-3574

X-RAY # TECH: KS

DATE: 6-13-06 #VIEWS: 3

ARRIVE TIME: Q0092 # 1

DEPART TIME: # PTS SEEN 1

PRELIMINARY REPORT:

AM

LEE COUNTY DETENTION CENTER
MEDICAL CHARGE FORM
(FORM #33)

INMATE NAME Owens, Rodney

DATE OF BIRTH _____ **RACE/SEX** _____

SOCIAL SECURITY# _____ **CELL** F-1

SERVICES & FEES

☐ SICK CALL	$10.00
☒ DOCTOR VISIT	$10.00
☐ DENTIST VISIT	$10.00
☒ PRESCRIPTION	$3.00 Naprosyn 500mg
☐ FOLLOW-UP VISIT	N/A

TOTAL OF MEDICAL SERVICES RENDERED $13.00

MEDICAL VERIFICATION SECTION

Authorized Nursing Staff Signature & Date [signature] 5/31/06

Inmate Signature & Date COPay

Inmate Account Payable Clerk Signature & Date

[signature]

☐ **PLEASE CHECK IF INMATE IS INDIGENT TO PAY THE ABOVE CHARGES.**

☐ **PLEASE CHECK IF INMATE IS ABLE TO PAY THE ABOVE CHARGES.**

HIV SEROLOY 86701
WESTERN BLOT 86689

ALABAMA DEPARTMENT OF PUBLIC HEALTH
BUREAU OF CLINICAL LABORATORIES

I.D. NUMBER 696010

PLEASE USE A BLACK PEN

Patient's Last Name | Patient's First Name | MI

Owens, Rodney J.

Address | Apt.

City [redacted] GLE State | Zip

[redacted]0 W/M

Phone

Counselor (Initials)

Date Collected / /

EIA Results: Indicated by Marked	WESTERN BLOT
(•) Negative	○ Negative
○ Not Done	○ Indeterminate
○ Positive	○ Positive
	○ Not Done

RACE: W B H A I U — SEX: M F — DOB (mmddyyyy)

ANALYST INITIALS

DATE REPORTED / /

☐ Birmingham ☐ Mobile
☐ Decatur ☒ Montgomery
☐ Dothan

Provider LEE COUNTY DETENTION CENTER — SITE CODE — CNTY

Address P.O. BOX 2407

City OPELIKA, AL 36803 State Zip

County Health Dept. CHR Number

Social Security Number - -

Medicaid Number

Provider Number

Has Patient Had a Previous Positive or Indeterminate Western Blot?

○ No ○ Yes ○ Unknown

Date / /

PATIENT SHOULD HAVE A TUBERCULIN SKIN TEST IF HIV POSITIVE

1997321024

REPORT COPY
Return to provider

ADPH CL-109 / REV 01-01

Bureau of Clinical Laboratories-Montgomery

PO BOX 244018, MONTGOMERY AL 36124-4018
Phone:(334) 260-3400 FAX:(334) 274-9800

Provider:
TKD JUSTICE CENTER
PO BOX 2407
OPELIKA, AL, 36801-0000
(000) 000-0000,
UNKNOWN DOCTOR

Accession 4018147
Requisition #: 4018147
Service Area:
CHR #:

ID: 1021172

Collected: 3/22/2006 @
Received: 3/23/2006 @ 9:36 AM
Reported: 3/24/2006 @ 3:16 PM

Patient:
Owens,Rodney,J
D.O.B.: [redacted]
Sex: M MALE
Phone: (000) 000-0000
SSN: [redacted]
Status: **Final Report**

Test Name	Result	Units	Normal Range	Notes
Serology Results				
VDRL, STS Qualitative	Non-Reactive			

Lab Director
William J. Callan,Ph.D.

Date Printed: 3/24/2006 3:16 PM >> PH - Panic High > AH - Abnormal High ~ A - Abnormal *** Final Page ***
Completed Between: 3/24/2006 - 3/24/2006 << PL - Panic Low < AL - Abnormal Low δ Delta Check Failed All Results Included

NOTE: Print firmly using blue or black ink to complete form.

Alabama Department of Public Health
TB Division
RSA Tower/201 Monroe Street
Montgomery, ALabama 36130-3017

TB

Skin Test Report

County Code 41 | Target Testing | PROJECT | CHR#

Last Name: Owens, Rodney J. | MI: J

[redacted] W/M

City

State | Zip Code | Home Phone

SSN: | Date of Birth: | SEX: M F

Race: W B AI A AN H/PI O

ETHNICITY: Hispanic or Latino: YES NO

Test Administered By: TB Staff; PH Nurse; Other

Site Test: Health Department; Other

Reason Tested: Health Care Worker; Medical Risk; Shelter; Student; Occupational; Foreign Born; Homeless; Jail/Prison; Not at Risk

Contact to Case/Suspect: YES NO

Risk Categories: A; B; C

PPD ONE:

Provider#: | Lot#: CL2212AA

Date of Test: 03-08-2006 | Antigen: AP TU (TU)

Provider#: | Date Read: 03-10-2006 | Result: 0 mm Not Read

PPD TWO:

Provider#: | Lot#:

Date of Test: - - | Antigen: AP TU

Provider#: | Date Read: - - | Result: mm Not Read

Race codes: W-White; B-Black; AI - American Indian; A-Asian; AN - Alaskan Native; H/PI-Hawaiian/Pacific Islander; O-Other

ADPH-TB - 26/REV-12-2002

LEE COUNTY DETENTION CENTER
P.O. BOX 2407
OPELIKA, AL 36803

4739494381

I hereby authorize the Lee County Sheriff's Office to use, disclose and/or obtain my health information as follows (check all that apply):

( ) use the following health information maintained by Lee County Sheriff's Office.

(✓) disclose the following health Information to:
~~LEE COUNTY SHERIFF~~
~~2311 GATEWAY DRIVE~~
~~OPELIKA, AL 36803~~

(✓) obtain the following health information from:
Dr. Charles Baker
Charlotte, NC

Specific description of the health information to be used/disclosed/obtained (include dates of service, type of service, etc) : _____

This health information is used/disclosed/obtained for the purpose (if Authorization requested by the patient put: "At the request of the individual"): _____

I understand that this health information may include information regarding drugs and alcohol, human immunodeficiency virus test results, and psychotherapy notes.

If the disclosure is for marketing purposes, will the Lee County Sheriff's Office directly or indirectly receive remuneration for the disclosure of health information? Yes ___ No ___ N/A ___.

By providi ...d as follows:

I underst... ...se to sign this Authorization and my treatment and/or payment

1. ...
2. ...
3. ...
4. ...
5. ...

NO Listing

...may refuse to sign this Authorization and my treatment

...ased may be subject to re-disclosure by the recipient of the Federal Privacy Rules.

...at any time by notifying the Lee County Sheriff's Office ...uses or disclosures prior to the receipt of the revocation.

...horization form after I sign it.

...n 2 / 6 / 07 (MM/DD/YR) or upon the "End of the research

_____ If an ... will cease to be valid 90 days from the date of signature.

Rosa
Signature of Patient or Patient Rep...

2/7/06
Date

Printed Name of Patient's Representative (if applicable)

Representative's Relationship to Patient (if applicable)

LEE COUNTY SHERIFF'S OFFICE

PATIENT AUTHORIZATION FOR USE AND/OR DISCLOSURE OF PROTECTED HEALTH INFORMATION

PATIENT INFORMATION

PATIENT NAME: Rodney J. Owens

SOCIAL SECURITY NO. [redacted]

DATE OF BIRTH [redacted]

LEE COUNTY SHERIFF'S OFFICE

02/03/2006 17:41:59 INMATE BOOKING SHEET PAGE 1

BOOKING NO: 060000608

INMATE NAME: OWENS RODNEY J
ALIAS:
ALIAS:
ADDRESS: [redacted]R.
CITY/ST/ZIP: C[redacted]01
HOME PHONE: [redacted]
DOB: [redacted]0 AGE: 46
PLCE BIRTH: COLUMBUS
STATE: GA
M. STATUS: SINGLE
RELIGION: BAP
GANG ASSOC:
SCARS/TATTOOS:
KNOWN ENEMIES:
REMARKS:

RACE: W SEX: F
HT: 5'11" HAIR: BRO
WT: 150 EYES: BLU
COMPLEX:
SSN: [redacted]5
DL ST: DLN:
SID:
LOCID: 31902

---------- NEXT OF KIN ----------

NEXT OF KIN: JOHNNY OWENS RELATIONSHIP: BROTHER
ADDRESS: PHONE: [redacted]
CITY/ST/ZIP: ,
REMARKS:

---------- EMPLOYER INFO ----------

Smith 5 76-4368 (706)

EMPLOYED: Y
EMPLOYER NAME: SELF EMPLOYED
ADDRESS:
CITY/ST/ZIP: ,
PHONE: 000-000-0000

---------- MEDICAL ----------

HANDICAPPED: N NEEDS: N
GLASSES: Y SMOKE: Y
MEDICAL NEEDS: NEEDS: [redacted]
PHYSICIAN: PHONE: 000-000-0000
REMARKS:

REMARKS:
REMARKS:

---------- PROPERTY ----------

CASH: $30.00
DESCRIPTION: STREET CLOTHES
ADD. PROPERTY: 1LIGHTER,1NECKLACE,1BELT
ADD. PROPERTY: 1CAP,1BOX CIG,1PACK OF GUM
ADD. PROPERTY:
BIN NUMBER: 73
VEH IMPOUNDED:
IMPOUND LOT:
REMARKS:
REMARKS:

I HAVE READ THE ABOVE ACCOUNTING OF MY PERSONAL INFORMATION, MEDICAL INFORMATION, MONEY, AND OTHER PROPERTY AND I FIND IT TO BE TRUE AND ACCURATE.

INMATE: Rodney Owens DATE: 2/3/06 TIME: _____

BOOK OFFICER: _____ DATE: 2/3/06 TIME: _____

LEE COUNTY SHERIFF'S OFFICE
02/03/2006 17:41:59 MEDICAL SCREENING FORM PAGE 2

Booking No: 060000608 Date: 02/03/2006 Time: 17:30 Type: NORMAL
Agency to Bill: LEE COUNTY Facility: COUNTY JAIL

Inmate Name: OWENS RODNEY J Race: W Sex: F
DOB: [redacted] Age: 46 SSN: [redacted] Height: 5'11" Weight: 150

Y 13. Have you recently been hospitalized or treated by a doctor?

Y 14. Do you currently take any non-prescription medication or medication prescribed by a doctor?

N 15. Are you allergic to any medication?

Y 16. Do you have any handicaps or conditions that limit activity?

N 17. Have you ever attempted suicide or ~~are~~ you thinking about it now?

Y 18. Do you regularly use alcohol or street drugs?

Y 19. Do you have any problems when you stop ~~drinking~~ or using drugs?

N 20. Do you have a special diet prescribed by a physician?

Y 21. Do you have any problems or pain with your teeth?

N 22. Do you have any other medical problems we should know about?

13- 6 months for lungs
14 Benedryl, Tylenol

I HAVE READ THE ABOVE ACCOUNTING OF MY MEDICAL ASSESSMENT AND I FIND IT TO BE TRUE AND ACCURATE.

INMATE: [signature] DATE: _____ TIME: _____

BOOK OFFICER: [signature] DATE: _____ TIME: _____

LEE COUNTY SHERIFF'S OFFICE

02/03/2006 17:41:59 INMATE CHARGE SHEET PAGE 3

BOOKING NO: 060000608 INMATE NAME: OWENS RODNEY J

CHARGE NO: 1 DISPOSITION: OPEN HOLD: Y

ALA STATUTE: # OF COUNTS: 0
OFFENSE: RECEIVING STOLEN PROPERTY 2ND WARRANT #:
CASE #:
BOND AMT: 3,000.00 FINE: $0.00
BAIL AMT: 3,000.00
INIT APPEAR: 00/00/0000 SENTENCE DATE: 00/00/0000
RELEASE DTE: 00/00/0000
ARREST DATE: 02/03/2006 ARST AGENCY: LCSO
ARST OFFICR: SURRETT COUNTY: LEE
COURT: JUDGE:
DEF ATTORNY: DIST ATTORNEY:
COMMENTS:
COMMENTS:
COMMENTS:

LEE COUNTY SHERIFF'S OFFICE

02/03/2006 17:41:59 MEDICAL SCREENING FORM PAGE 1

Booking No: 060000608 Date: 02/03/2006 Time: 17:30 Type: NORMAL
Agency to Bill: LEE COUNTY Facility: COUNTY JAIL

Inmate Name: OWENS RODNEY J Race: W Sex: F
DOB: [redacted] Age: 46 SSN: [redacted] Height: 5'11" Weight: 150

N 1. Is inmate unconscious?

N 2. Does inmate have any visible signs of trauma, illness, obvious pain and bleeding, requiring immediate emergency or doctor's care?

N 3. Is there obvious fever, swollen lymph nodes, jaundice or other evidence of infection that might spread through the facility?

N 4. Any signs of poor skin condition, vermin, rashes or needle marks?

N 5. Does inmate appear to be under the influence of drugs or alcohol?

N 6. Any visible signs of alcohol or drug withdrawal?

N 7. Does inmate's behavior suggest the risk of suicide or assault?

N 8. Is inmate carrying any medication?

N 9. Does the inmate have any physical deformities?

N 10. Does inmate appear to have psychiatric problems?

11. Do you have or have you ever had or has anyone in your family ever had any of the following?

N a. Allergies	N f. Fainting Spells	Y k. Seizures
N b. Arthritis	N g. Hearing Condition	N l. Tuberculosis
Y c. Asthma	Y h. Hepatitis	N m. Ulcers
N d. Diabetes	N i. High Blood Pressure	N n. Venereal Disease
Y e. Epilepsy	N j. Psychiatric Disorder	N o. Other (Specify)

Other: Lung Disease, Take meds for Seizures

12. For females only:

X a. Are you pregnant?

X b. Do you take birth control pills?

X c. Have you recently delivered?

LEE COUNTY SHERIFF'S OFFICE

02/03/2006 17:41:59 INMATE BOOKING SHEET PAGE 2

BOOKING NO: 060000608 INMATE NAME: OWENS RODNEY J

COURT:
JUDGE:
REMARKS:
REMARKS:
ATTORNEY ON REC:
PHONE: 000-000-0000

BOOK DATE: 02/03/2006 BOOK TIME: 17:30 BOOK TYPE: NORMAL

ARREST DATE: 02/03/2006
ARREST DEPT: LCSO
ARRST OFFICER: SURRETT
PROJ. RLSDATE: 00/00/0000
SEARCH OFFCR: SCROGGINS
TYPE SEARCH: PAT
INTOX RESULTS:

BOOKING OFFICER: DIX
CELL ASSIGNMENT: F1
MEAL CODE: 01 LEE COUNTY
FACILITY: 01 COUNTY JAIL
CLASSIFICATION:
WORK RELEASE: N

HOLDS: Y
AGENCY: LCSO REASON: MCKANE
AGENCY: REASON:
AGENCY: REASON:
AGENCY: REASON:

NOTES:
NOTES:
NOTES:

Lee County Detention Center

INMATE REQUEST SLIP

E 6
LOCATION

Name Rocky Chris Date

☐ Telephone Call ☑ Doctor ☐ Dentist ☐ Time Sheet

☐ Special Visit ☐ Personal Problem ☐ Other

Briefly Outline Your Request. Give To Jailer

Pain in my Back

Do Not Write Below This Line - For Reply Only

6/25/06 your on Naprosyn already for pain.

Nurse Griffith

Approved Denied Collect Call

Lee County Detention Center

INMATE REQUEST SLIP

F1
LOCATION

Name Rodney Owens Date 2-27-06

☐ Telephone Call ☐ Doctor ☐ Dentist ☐ Time Sheet

☐ Special Visit ☐ Personal Problem ☒ Other

Briefly Outline Your Request. Give To Jailer

I need to see Nurse Stewart about my Inhaler the Doctor wrote. I am having problems Breathing !! & Sleeping.

Do Not Write Below This Line - For Reply Only

2/27/06 Saw M.D. Today

Nurse Stewart

Approved _____ Denied _____ Collect Call _____

Lee County Detention Cente

INMATE REQUEST SLIP

F1
LOCATION

Name Rodney Owens Date 05/21/06

☐ Telephone Call ☑ Doctor ☐ Dentist ☐ Time Sheet

☐ Special Visit ☐ Personal Problem ☐ Other

Briefly Outline Your Request. Give To Jailer

Mrs Stewart
I ask you about some
antibacterial soap, you said
fill this out.
Thank you

Do Not Write Below This Line - For Reply Only

5/22/06 Dial Soap sent
Nurse Grisette

Approved _____ Denied _____ Collect Call_____

NOTES

NAME: Owens, Rodney SS# [redacted]

DOB: [redacted] AGE: 46 SEX: M RACE: W

DRUG ALLERGIES: Ø TETNUS: _____

NATURE OF PROBLEM OR REQUEST: Fell in Shower - Rt ankle & L Back.

I CONSENT TO BE TREATED BY HEALTH STAFF FOR THE CONDITION DESCRIBED.

_____
SIGNATURE

HEALTH CARE DOCUMENTATION

176 lk 5/19

SUBJECTIVE:

OBJECTIVE: BP_____ P_____ R_____ T_____ O2_____

ASSESSMENT:

05/31/06 Lee County Detention Center Rodney Owens #252041575
This 46 YOWM slipped and fell in the shower and twisted his right ankle. He said he pulled a muscle in the right low back.
Physical Exam: Alert, walks in with a normal comfortable gait. There is no limp. His right ankle is swollen and tender especially at the origin of the ATF ligament but not at the insertion. The skin is intact, the joint is stable. He has no midline tenderness in the back. He is a little bit tender in the right low back musculature. Straight leg raise is negative.
Impression: Slip and fall with right ankle sprain and right low back muscle strain.
Plan: Naprosyn 500 mg b.i.d. #14. Recheck in one week if not better.

PLAN:

Naprosyn 500 BID #14

REFER TO:_____ PA/PHYSICIAN_____ MENTAL HEALTH_____ DENTAL_____

SIGNATURE_____ TITLE MD DATE 5/31/06 TIME 0929

JOHN H MCFARLAND MD
AM8104894
AL11404

5/31/06

NOTES

NAME: Owens, Rodney SS# [redacted]

DOB: [redacted] AGE: 46 SEX: M RACE: W

DRUG ALLERGIES: Ø TETNUS: _____

NATURE OF PROBLEM OR REQUEST: Fell in Shower Sunday Night

I CONSENT TO BE TREATED BY HEALTH STAFF FOR THE CONDITION DESCRIBED.

_____
SIGNATURE

HEALTH CARE DOCUMENTATION

SUBJECTIVE:

OBJECTIVE: BP 120/70 P_____ R_____ T_____ O2_____

ASSESSMENT: I/m Alert & Responsive TO PPT I/m c/o Fell out & Shower injury TO Rt Ankle it's Swollen Red & Purple c/o c/o & Back pain Ø other c/o

PLAN: ice motrin BID See MD in AM TOO Late for the Keep Ankle. P

REFER TO: _____ PA/PHYSICIAN _____ MENTAL HEALTH_____ DENTAL_____

SIGNATURE Stewart TITLE LPN DATE 5/30/06 TIME 1345

NOTES

NAME: Owens Rodney SS# [redacted]

DOB: [redacted] AGE: 46 SEX: M RACE: W

DRUG ALLERGIES: Ø TETNUS: _____

NATURE OF PROBLEM OR REQUEST: _____

I CONSENT TO BE TREATED BY HEALTH STAFF FOR THE CONDITION DESCRIBED.

_____
SIGNATURE

HEALTH CARE DOCUMENTATION

167#
5'11"

SUBJECTIVE:

OBJECTIVE: BP 120/70 P_____ R_____ T_____ O2_____

ASSESSMENT:

02/28/06 Lee County Detention Center Rodney Owens #253041575

This 46 YOWM is having trouble sleeping and wants his inhaler. He is having anxiety attacks. He thinks he had a seizure but there was no loss of consciousness or tongue biting or incontinence. He has just been very anxious. He says he is "starving".

Physical Exam: alert, comfortable gait. He certainly doesn't look like he is starving. HEART: Regular. LUNGS: Clear; no forced expiratory wheezes or other wheezes other than audible wheezes that he can produce when I ask him to just breathe quietly. He is able to breathe quietly. There are no true bronchospastic wheezes at any time. ABDOMEN: Soft and nontender.

Impression: Anxiety; history of inhaler use and tobacco abuse.

Plan: We will try again to get records. He says his doctor, Dr. Charles Bander, is at the Medical University of South Carolina in Charleston, SC, rather than Charolette, NC. His sister apparently is getting information to get those records. We will check his weight every week or two. Recheck by me as needed. Mental Health officer evaluation.

PLAN:

Cont 9-1-2006

REFER TO:_____ PA/PHYSICIAN_____ MENTAL HEALTH_____ DENTAL_____

SIGNATURE JOHN H MCFARLAND MD AM8104894 TITLE MD DATE 2-28-06 TIME 0912

03/29/06 wt 170

NOTES

NAME: Owens Rodney SS# [redacted]

DOB: [redacted] AGE: 46 SEX: M RACE: W

DRUG ALLERGIES: Ø TETNUS: _____

NATURE OF PROBLEM OR REQUEST: Lung Dz

I CONSENT TO BE TREATED BY HEALTH STAFF FOR THE CONDITION DESCRIBED.

_____
SIGNATURE

HEALTH CARE DOCUMENTATION

SUBJECTIVE:

02/08/06 Lee County Detention Center Rodney Owens #253041575

This 46 YOWM said he had a lung disease with a fungus and has to take Xopenex by nebulizer machine several times a day. He also smokes two packs a day down to one half pack per day. He gets anxiety attacks easily. Apparently his doctor in South Carolina.

Physical Exam: Alert, no distress, comfortable gait. HEART: Regular. LUNGS: Clear; no wheezes at all not even with forced exhalation. SKIN: he has a healing area of superficial abrasion but no or minimal bruising in the left posterior lower chest. There is no crepitus or deformity in the area. MSK: The low back muscles are nontender to palpation. Straight leg raise is negative. He has a normal comfortable gait.

Impression: Lung disease; tobacco abuse.

Plan: I told him we will let him have his Xopenex on hand and if the nurse hears some wheezes we will let him use his nebulizer machine. However, since Xopenex and Albuterol can stimulate his central nervous system it wouldn't be good for him just to take it because he feels anxious because it may make him more anxious. In the meantime he can have some Tylenol or Motrin prn discomfort from his fall and minor contusion/abrasion. Medical records will be sent for. Recheck prn.

PLAN: Med. records

Tylenol / motrin prn

REFER TO:_____ PA/PHYSICIAN_____ MENTAL HEALTH_____ DENTAL_____

SIGNATURE _____ TITLE MD DATE 2-8-06 TIME 0903

JOHN H MCFARLAND MD
AM8104894
AL 11404

2/8/06

Note: Dr. Charles Baron has no listing in

NOTES

NAME: Owens Rodney SS# [redacted]

DOB: [redacted] AGE: 46 SEX: M RACE: W

DRUG ALLERGIES: Ø TETNUS: _____

NATURE OF PROBLEM OR REQUEST: Lung problems.

I CONSENT TO BE TREATED BY HEALTH STAFF FOR THE CONDITION DESCRIBED.

_____
SIGNATURE

HEALTH CARE DOCUMENTATION

SUBJECTIVE:

OBJECTIVE: BP 120/70 P 76 R 20 T _____ O2 96 RA

ASSESSMENT: I/m c/o lung problems on Nebulizer & meds for it not to Lisinopril also Lasix 40mg & Lopressor. Chest Clear bp 120/70 VS Stable dr to renew Meds & meds

PLAN: will see MD in AM

REFER TO: _____ PA/PHYSICIAN _____ MENTAL HEALTH _____ DENTAL _____

SIGNATURE L Stewart TITLE LPN DATE 8/7/06 TIME 1450

Lee County Detention Center

INMATE REQUEST SLIP

F1
LOCATION

Name Rodney Owens Date 05/30/06

☐ Telephone Call ☐ Doctor ☐ Dentist ☐ Time Sheet

☐ Special Visit ☐ Personal Problem ☐ Other

Briefly Outline Your Request. Give To Jailer

Mrs Stewart
I fell in the Shower
and Hurt my ankel, Can I
see Someone about this.
2nd Request

Do Not Write Below This Line - For Reply Only

5/30/06

Sick call
See Nurse in AM

Approved _____ Denied _____ Collect Call _____

All Request Will Be Routed Through The Sergeant Over The Jail, Then Forwarded To Those The Request is Directed.

Lee County Detention Center

INMATE REQUEST SLIP

F1
LOCATION

Name Rodney Owens Date 05/28

☐ Telephone Call ☐ Doctor ☐ Dentist ☐ Time Sheet

☐ Special Visit ☐ Personal Problem ☐ Other

Briefly Outline Your Request. Give To Jailer

Mrs Stewart I feel my ankel is ~~so~~ swollen needs attention

Thankyou

Do Not Write Below This Line - For Reply Only

5/30/06 Sick Call

Nurse Sharp

Approved _____ Denied _____ Collect Call _____

NOTES

NAME: Owens, Rodney SS# [redacted]

DOB: [redacted] AGE: 46 SEX: M RACE W

DRUG ALLERGIES: none TETNUS: _____

NATURE OF PROBLEM OR REQUEST: review x-rays (wants more x-rays)

I CONSENT TO BE TREATED BY HEALTH STAFF FOR THE CONDITION DESCRIBED.

_____
SIGNATURE

HEALTH CARE DOCUMENTATION

SUBJECTIVE: injury 3 wk

OBJECTIVE: BP _____ P _____ R _____ T _____ O2 _____

ASSESSMENT:

06/20/06 Lee County Detention Center Rodney Owens #253041575
This 46 YOWM is about three and a half weeks after his injury. He inverted his right ankle and had a sprain. X-rays are back and are negative showing no fracture. He says he fell on his back and wondered about x-rays of his back. I explained that that would be low yield and not likely to show anything since he just slipped and fell from a standing position and not from a height or not in a car accident, etc.
Physical Exam: He walks with a normal comfortable gait. He seems to be careful about his right ankle. He has some tenderness above the lateral medial malleolus. There is mild swelling only. His back is a little bit tender at the left lower lumbar area. There is no midline tenderness. Straight leg raise is negative. In fact, he has comfortable spontaneous leg swing as he sits.
Impression: Ankle sprain; back muscle spasm.
Plan: We will see about putting him in a right ankle flexion splint if that is okay from a security standpoint. Recheck in two or three weeks.

PLAN:

Naproxen 375 BID x 20
@ Ankle flexion splint.
RTC 2-3wks

REFER TO: _____RA/PHYSICIAN_____MENTAL HEALTH_____DENTAL_____

SIGNATURE _____ TITLE M DATE 6/20/06 TIME 0945
(MCFARLAND)

Lee County Detention Center

INMATE REQUEST SLIP

F-1
LOCATION

Name Rodney Owens Date 6/12/06

☐ Telephone Call ☐ Doctor ☐ Dentist ☐ Time Sheet

☐ Special Visit ☐ Personal Problem ☑ Other

Briefly Outline Your Request. Give To Jailer NURSE. STEWART

I NEED MY BACK CHECKED FROM WHEN I FELL IN THE SHOWER. I WANT IT X-RAYED ALSO FOR FRACTURES.

THANKS FOR YOUR TIME

Do Not Write Below This Line - For Reply Only

6/19/06 You will see the doctor again Tuesday - you can ask him then.

NURSE GRIFFITH

Approved _____ Denied _____ Collect Call _____

NOTES

NAME: Owens Rodney SS# [redacted]

DOB: [redacted] AGE: 46 SEX: M RACE: W

DRUG ALLERGIES: Ø TETNUS: _____

NATURE OF PROBLEM OR REQUEST: Follow-up L ankle

I CONSENT TO BE TREATED BY HEALTH STAFF FOR THE CONDITION DESCRIBED.

SIGNATURE

HEALTH CARE DOCUMENTATION

174

SUBJECTIVE:

OBJECTIVE: BP_____ P_____ R_____ T_____ O2_____

ASSESSMENT:

06/13/06 Lee County Detention Center Rodney Owens #253041575

This 46 YOWM says his back and his ankle are worse.

Physical Exam: He is swollen and tender on the lateral aspect. He is still walking on it. He walked in fairly comfortably. His back is stiff and uncomfortable. He has some generalized discomfort; in fact he winces with even the slightest touch on the ankle or the back.

Impression: Back and ankle pain.

Plan: We will make an x-ray of that right ankle. I don't think it is broken but we will document that. Flexeril 10 mg b.i.d. #10 and Naprosyn 500 mg b.i.d. #14. Recheck in one week.

PLAN: Xray @ Ankle Callup 6/13/06

Flexeril 10 BID #10

Naprosyn 500 BID #14

Ref 1 wk

REFER TO:_____ PA/PHYSICIAN_____ MENTAL HEALTH_____ DENTAL_____

SIGNATURE JOHN H MCFARLAND MD TITLE MD DATE 6-13-06 TIME 0738

AM8104894

AL11404

Ace Wrap applied